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MEDICAID'S QUALITY CONTROL SYSTEM IS NOT REALIZING ITS FULL POT--ETC(U)
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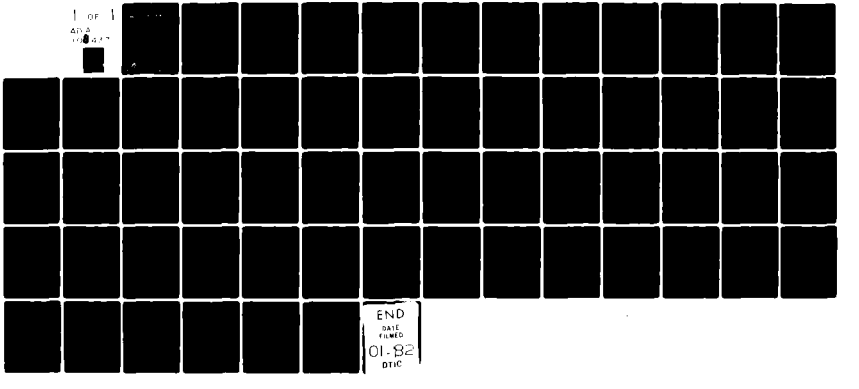

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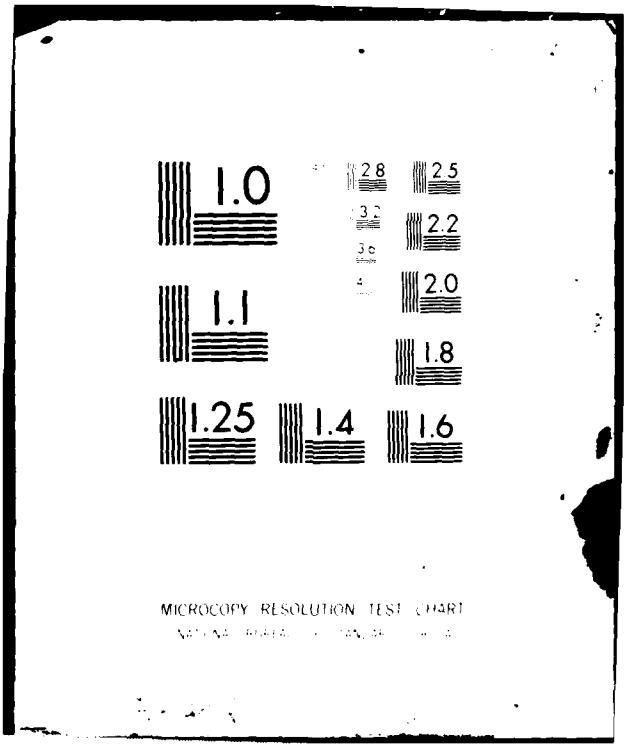
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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Medicaid's Quality Control System Is Not Realizing Its Full Potential

Medicaid's quality control program (which includes analyses of a sample of cases) identifies problems which result in erroneous payments and devises methods for overcoming these problems. Potentially severe penalties against States exceeding target error rates have been tied to the program, resulting in quality control focusing on data collection instead of corrective action. GAO recommends that the Congress establish a balanced system of less severe penalties for poor State performance and rewards for good performance. This would redirect the program toward making sure that problems are corrected. In turn, future erroneous payments would be minimized.

Many inaccuracies and weaknesses in sample cases cast doubt on the validity of quality control findings. Therefore, GAO believes the error rates developed by quality control are not adequate bases for assessing penalties.

GAO also recommends to the Secretary of Health and Human Services several modifications to quality control processes which would provide more useful information for corrective action purposes.

GAO/HRD-82-6
OCTOBER 23, 1981

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-204749

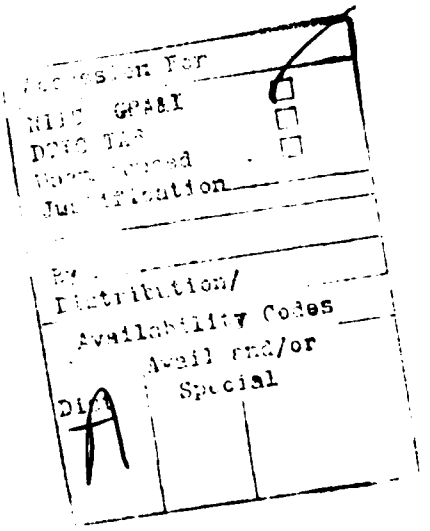
To the President of the Senate and the
Speaker of the House of Representatives

This report discusses how Medicaid's quality control program could be modified to focus on developing corrective actions to reduce the extent of erroneous payments made under Medicaid. We believe legislative action to provide a balanced system of penalties and rewards for State program management as reflected by quality control findings, along with the administrative actions recommended in this report, will accomplish this. We decided to review the quality control program because it is a primary means of identifying actions needed to reduce erroneous Medicaid payments, which are estimated to exceed $1 billion a year.

Copies are being sent to the Director, Office of Management and Budget, and the Secretary of Health and Human Services.

Milton J. Socolar

Acting Comptroller General
of the United States



COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MEDICAID'S QUALITY CONTROL SYSTEM IS NOT REALIZING ITS FULL POTENTIAL

D I G E S T

Based on data from the Medicaid Quality Control program, the Health Care Financing Administration (HCFA) estimates that about $1.2 billion in erroneous Medicaid payments are made annually. The quality control program is a primary means for identifying the amount and causes of erroneous payments and of devising methods for overcoming the causes.

A statistically projectable sample of Medicaid cases and the health service claims paid for these cases are analyzed to determine if (1) the individual(s) in each sampled case were eligible for Medicaid, (2) the amount paid for each claim was correct, and (3) any other liable parties (Medicare, insurance companies, etc.) paid before Medicaid. HCFA re-reviews a statistical subsample of the State sample cases to validate State findings.

The quality control program is to devise plans to correct problems identified during the sample review that resulted in erroneous payments so similar problems will be eliminated or minimized in the future. The end result of quality control should be to lower the amount of erroneous payments in future periods. GAO undertook this review to determine the validity of the data developed and to evaluate Medicaid quality control. It identified a number of areas that hampered the quality control program from fully realizing its objectives.

PENALTIES HAVE MISFOCUSED QUALITY CONTROL

To encourage States to improve their Medicaid administration, the Congress and HCFA have tied the error rate developed by quality control to fiscal sanctions. States with error rates exceeding preestablished target rates can have the percentage of their Federal sharing rate reduced by the percentage points by which the target rate is exceeded. Such penalties can result in the loss of millions of dollars

in Federal money, which the States must then replace with their money. For example, Illinois exceeded its target error rate by 1.8 percent and could have been penalized $3.9 million.

GAO believes that the threat of large fiscal penalties has hindered quality control from reaching its full potential because it has focused State and HCFA attention on the error rates instead of on corrective action. States resist citing errors because they view them as potential sources of penalties rather than as indications of administrative weaknesses, the correction of which would reduce erroneous payments. Because the error rates are tied to the penalties, HCFA has placed its emphasis on developing quality control processes and policies which will provide statistically defensible error rates which can withstand challenge if penalties are assessed. The penalties have led to a somewhat adversary relationship between the States and HCFA, and corrective action has assumed a secondary role in the quality control process. (See ch. 2.)

GAO believes that quality control should be refocused on its primary objective--minimizing future erroneous payments. This could be accomplished by

--reducing the magnitude of the penalties for poor performance and

--providing rewards of similar magnitude for good performance.

Because erroneous payments result from administrative errors, penalties for poor performance should be assesssed against Federal sharing in State administrative costs rather than sharing in health service payment costs. Rewards could also be based on sharing in administrative costs. GAO suggests that the Congress enact legislation to establish such a system of rewards and penalties. Absent such action, because of the questionable accuracy of the initial error rates developed by quality control discussed below, GAO suggests that the Congress suspend its directive to assess sanctions based on error rates until the quality control program is improved. (See pp. 14 and 15.)

In commenting on these recommendations (see p. 15), the Department of Health and Human Services (HHS) said it believed more study was necessary before it could take a definitive position.

QUESTIONABLE ACCURACY OF QUALITY CONTROL FINDINGS

The validity of the error rates developed by quality control as a basis for establishing State target error rates is questionable. GAO reviewed 982 cases, which represented about half of those in HCFA's subsample of five State samples. GAO identified significantly more erroneous payments due to ineligibility, claims processing errors, and failure to use liable third parties. (See pp. 18 to 21). In addition, GAO also identified three weaknesses which raise questions about the accuracy of other quality control findings.

--HCFA's quality control reviews lacked independence. (See p. 23.)

--Case findings were based on insufficient information. (See p. 23.)

--Some States had prior knowledge of the cases HCFA would subsample. (See p. 25.)

GAO recommends that the Secretary of HHS improve the independence of HCFA's quality control reviews. (See p. 26.)

In commenting on this recommendation, HHS disagreed with GAO's approach to improving the independence of HCFA's reviews. GAO believes its recommendation is appropriate and should be implemented because it will improve the reliability of quality control data. (See p. 27.)

CORRECTIVE ACTION ASPECT NEEDS EMPHASIS

The corrective action aspect of the quality control program lacks clear direction and leadership. Because of the emphasis placed on data collection by HCFA and the States in response to potential penalties, corrective action has not been as effective as it could be. (See pp. 28 to 32.) GAO also identified four areas where quality control procedures could be modified to provide more useful data for corrective action purposes:

--Quality control's current practice of reviewing claims paid for the cases selected for eligibility review does not assure that a representative sample of all types of claims are reviewed. If claims for payment review were selected from the universe of paid claims, quality control would be more assured of uncovering all claims processing problems. (See p. 33.)

--The data reported by quality control overstate the amount that could be saved by eliminating eligibility errors. This complicates the State's cost/benefit analysis of planned corrective actions. (See p. 35.)

--HCFA's policy of using the approved State Medicaid plan rather than the Medicaid regulations as the ultimate criteria for identifying errors results in some program weaknesses not being identified and can result in States being treated differently. (See p. 36.)

--Quality control does not determine the effectiveness of third-party resource utilization or recovery efforts. (See p. 37.)

GAO recommends that the Secretary take a series of actions to overcome these weaknesses. (See p. 38.)

HHS generally agreed with GAO's recommendations to the Secretary, except for those dealing with using the Medicaid regulations as the ultimate criteria for determining quality control findings and including an assessment of third-party resource utilization or recovery efforts under quality control. GAO continues to believe its recommendations are valid and would improve the effectiveness of the quality control program. (See pp. 39 to 41.)

Contents

ABBREVIATIONS

AFDC	Aid to Families With Dependent Children
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MQC	Medicaid Quality Control
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Congress has been concerned about erroneous Medicaid payments to health services providers for ineligible recipients and for ineligible services since Medicaid began in 1966. Before 1978 the Health Care Financing Administration (HCFA), Department of Health and Human Services (HHS), which administers Medicaid, attempted unsuccessfully to control erroneous payments to ineligible recipients through an eligibility quality control program. In 1978 HCFA implemented a new Medicaid Quality Control (MQC) program, which changed the eligibility sampling procedures and added an examination of the claims processing and third-party liability systems. This new system incorporated fiscal penalties for States that fail to meet established target MQC eligibility error rates beginning with the April-September 1979 period.

This report discusses HCFA's administration of the MQC program and resulting problems which have limited its usefulness in reducing Medicaid payment errors. It also discusses the error rate results.

MEDICAID PROGRAM BACKGROUND

The Medicaid program, established in 1965 under title XIX of the Social Security Act, as amended (42 U.S.C. 1396), is a grant-program in which the Federal Government pays 50 to 78 percent of a State's cost of providing health care to the poor. At the Federal level, the Administrator, HCFA, has responsibility for the Medicaid program. Ten HCFA regional offices handle field activities.

Generally, persons receiving public assistance under title IV, Aid to Families with Dependent Children (AFDC), or title XVI, Supplemental Security Income (SSI), of the Social Security Act are eligible for assistance under Medicaid. These persons are referred to as "categorically needy." Persons whose incomes or other resources exceed established standards to qualify for public assistance programs but are not sufficient to meet the costs of necessary health care may also be entitled to Medicaid benefits if the State chooses to use this option. These people, eligible for Medicaid but not cash assistance, are referred to as "medically needy."

Within federally set limits, States determine the scope of Medicaid services offered and the reimbursement rate for these services, and they normally make payments directly to the providers who render covered services to eligible individuals. Because the States generally determine the eligibility level for the welfare programs, they exercise a great deal of control over the income eligibility levels for Medicaid.

All of these variations--in benefits offered, in groups covered, in income and resource standards, and in levels of reimbursement--mean that Medicaid programs differ greatly from State to State.

All States except Arizona have Medicaid programs, as do the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. Each jurisdiction initiates and administers its own program, the nature and scope of which are contained in its State plan. After being approved by the cognizant HCFA regional administrator, the plan provides the basis for Federal financial participation in the program.

The cost of the Medicaid program has grown dramatically: from around $1.6 billion in fiscal year 1966 to over $24 billion in fiscal year 1980. HCFA officials estimate that during that time the number of recipients has grown from under 11 million to over 22 million.

This growth has been accompanied by several problems. HCFA estimated that, in the July-December 1978 period (for which we reviewed MQC findings), approximately $461 million was paid for health services to ineligible beneficiaries, $74 million was lost in unrecovered third-party liability, and $100 million was wasted through claims processing errors. The resulting effect--approximately $635 million, or about 7 percent of all Medicaid payments in that period, were erroneous.

MQC PROGRAM BACKGROUND

The MQC program was designed as a coordinated effort by the State and Federal governments to improve the administration of the Medicaid program. Its primary objective is to measure, identify, and eliminate or reduce dollar losses. It is designed to ensure that Medicaid funds go only to beneficiaries who are eligible under Federal and State law; that claims are paid only for covered Medicaid services to eligible providers in the correct amount; and that third parties (Medicare, workmen's compensation, insurance companies, etc.) are fully utilized, making Medicaid the payer of last resort.

MQC is supposed to accomplish its objective by examining a statistical sample 1/ of the State's Medicaid cases to determine (1) how accurate eligibility determinations are, (2) whether any third-party liability existed and was properly utilized, and (3) whether the amount paid for claims was correct under the State's policies contained in its approved Medicaid plan. Because the sample is statistical and, therefore, projectable to the State's universe of cases, the errors identified in and error rates established for the sample are indicative of similar errors and error rates in the universe. Therefore, by correcting the causes of errors in the sample, the States should prevent similar errors throughout future State Medicaid operations.

Also, States are required to correct errors found in the sample cases and act to minimize similar errors in the future. Corrective actions planned by each State must be outlined in a corrective action plan submitted to HCFA annually.

HCFA independently reviews a subsample of the State MQC sample to ensure that the State is properly reviewing MQC cases. The results of the HCFA subsample reviews are used to modify the error rates determined by the State.

History

Federal Medicaid regulations in the early 1970s required the States to estimate through statistical sampling the percentage of ineligible persons receiving medical assistance and act to reduce the percentage. However, these requirements were suspended in April 1973 so the States could concentrate their resources on the eligibility testing of AFDC recipients.

In June 1975, HHS issued regulations requiring States to initiate another quality control program applying only to eligibility. However, HHS believed this program was ineffective and replaced it with the current MQC program in 1978.

1/The sample is normally stratified by three groups--SSI recipients, AFDC recipients, and recipents eligible only for Medicaid. The SSI and AFDC strata normally include the same cases included in the quality control programs for SSI and AFDC. MQC accepts the eligibility determination decisions of the other two quality control programs and reviews only claims payment and third-party liability for those strata. For the Medicaid-only stratum, MQC reviews all three aspects. For cases found ineligible by SSI or AFDC quality control, in the base period, MQC reviewed the cases to determine possible eligibility under other Medicaid eligibility groups, such as the medically needy.

The current MQC program is designed to assess the States' Medicaid eligibility determinations and for the first time to assess the accuracy of payments for services provided Medicaid recipients, including the use of third-party resources. MQC regulations also contain provisions for imposing fiscal penalties on States which do not meet established eligibility error rate targets for the April-September 1979 period and all subsequent periods. The first procedures for this new MQC program provided for establishing target reduction rates based on the higher of the weighted average mean of all States' rates or a 15.7-percent reduction in the State's previous rate. These procedures were changed by section 201 of the Labor-HHS Appropriation Bill for fiscal year 1980 (H.R. 4389), as referenced in the Continuing Resolution for fiscal year 1980 (Public Law 96-123), which directed the Secretary of HHS to issue regulations requiring States to reduce their payment error rate for Medicaid eligibility determinations to 4 percent by September 30, 1982.

HCFA's implementing regulations require States to make progress in reducing their error rates each year beginning in fiscal year 1980. Progress will be measured from an error rate determined by the State and validated by HCFA for a 6-month base period, July-December 1978. This base period and the next reporting period, April-September 1979, have been reviewed and error rates established for the individual States. 1/ (See app. I for a list of States that did not reach their first reduction targets). Subsequent quality control reviews are scheduled on a 6-month cycle from October through March and from April through September each year.

Fiscal penalties and corrective action

HCFA is required to notify each State failing to meet its error rate reduction targets that Federal matching funds will be reduced if it cannot show within 65 days that it made a good faith effort to meet them. If the State can convince the Secretary of HHS that it made a good faith effort to meet its target, HCFA may waive the reduction of Federal financial participation. However, if the State does not convince the Secretary, HCFA may reduce the State's Federal matching Medicaid funds. The amount of the reduction is computed from a formula contained in 42 CFR 431.801/802. This formula includes the extent to which the State failed to reach its target error rate.

1/HCFA exempted the January-March 1979 period from Medicaid quality control review.

For the first reporting period subject to fiscal penalties, April-September 1979, the Secretary of HHS provided the States two ways to avoid these penalties. First, the States could apply for a waiver of the penalties due to circumstances beyond their control. Second, the States could submit corrective action plans acceptable to HCFA. Acceptance of the plans would suspend imposition of sanctions because it showed the State's intent to improve. All 18 States liable for fiscal sanctions submitted corrective action plans which HCFA accepted. The plans are to be reviewed in October 1981 to determine if implementation of the plans justifies permanent suspension of the penalties.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this review were to determine the validity of the data used to establish the error rates for the base period (July-December 1978) and to evaluate MQC's corrective action process. We chose to examine the base period data because the error rates established for that period determined the error levels on which HCFA set error rate reduction targets for fiscal penalties.

We made our review at the HCFA central office in Baltimore; at HCFA regional offices in Atlanta, Chicago, Dallas, and Seattle; and in the States of Alabama, Georgia, Illinois, Louisiana, Oklahoma, Tennessee, Texas, and Washington. We selected these States so that our review would cover (1) relatively large and small Medicaid programs, (2) different ranges of covered services and eligibility groups, (3) high and low error rates for the base period, and (4) varied geographical locations. Because of these selection criteria, we believe the results of our review are indicative of the problems in the MQC program nationwide.

In all the States, we interviewed Medicaid MQC and program officials and examined MQC processes, payment policies, eligibility policies, and corrective action activities to identify issues that reduce MQC's effectiveness.

In Alabama, Georgia, Louisiana, Oklahoma, and Washington, we examined the base period HCFA subsample cases for July, August, and December 1978. In Alabama we also examined the September 1978 cases. To reduce the time needed to complete our work, we did not review all the months in the base period. However, we reviewed all the subsample cases for the months we selected. We reviewed months at the beginning and end of the period to determine if changes in quality control processes and/or accuracy of case reviews had occurred during the period.

In reviewing subsample cases, we examined only the eligibility determinations for the Medical Assistance Only stratum. 1/ We reviewed the claims processing and third-party liability areas for all three strata. In Washington we examined claims payment and third-party liability determinations only for December because of time limitations. We used applicable Federal regulations, MQC manuals, HCFA Action Transmittals changing review policy, State Medicaid Plans, and State eligibility and payment policy manuals as the criteria for conducting our reviews. To make our findings comparable to MQC's, we used HCFA's criteria for determining errors and its methods for determining the dollar impact of errors although, as discussed in chapter 3, in some instances we disagree with these criteria and methods.

In the HCFA regional offices, we examined the case re-review processes and support activities and corrective action activities and discussed MQC strengths, weaknesses, and problems with regional officials.

We discussed all of our case review findings with cognizant HCFA regional officials and State MQC officials and resolved most of our differences.

1/Normally, the MQC program uses the same sample of AFDC and SSI recipients as the quality control programs for these two programs, and Medicaid accepts the eligibility determinations made under the other quality control programs. Therefore, Medicaid quality control normally reviews only the eligibility of Medical Assistance Only cases, and we reviewed only such cases.

CHAPTER 2

THREAT OF POTENTIALLY SEVERE FISCAL PENALTIES IS NOT ACHIEVING DESIRED RESULTS

To encourage States to improve their Medicaid program administration, the Congress and HHS have taken steps to impose potentially severe fiscal sanctions against States having rates of erroneous payments that exceed error rate tolerances based on the MQC system. In our opinion, the potential severity of these penalties has inappropriately focused the MQC program's activities on developing defensible error rates rather than on developing and implementing meaningful corrective action programs, which should be the main objective of the MQC program. Because of the MQC weaknesses identified, we believe the error rates developed are not suitable for penalizing States.

To overcome the problems which hamper MQC's effectiveness in identifying and eliminating errors in the Medicaid program, we believe that MQC needs a balanced system of penalties for poor performance and rewards for good performance. Such a system should create an environment in which both the States and HCFA can view the MQC system as a means of improving Medicaid management.

SEVERE PENALTIES CAN RESULT IN PROBLEMS NOT BEING RESOLVED

If a State is penalized because its eligibility error rate exceeds its target error rate, the State must come up with additional State funds for its Medicaid program equal to the amount of the penalty or cut back on the program to make up the difference. The potential loss of Federal funds naturally gives the States an incentive to lower their error rates, which is the effect intended by the Congress and HHS. However, the potential penalties were so large that they focused the States' attention more on striving to keep the error rate developed under the MQC program low by resisting citing errors, often based on States' interpretations of HCFA regulations, than on taking corrective action to eliminate their causes. Because corrective action is the ultimate purpose of MQC, the threat of penalties has partially negated its expected benefits.

Five of the eight States we visited were threatened with penalties because their eligibility error rates for the first penalty period, April-September 1979, exceeded their target rates. The potential penalties ranged from $155,000 in Louisiana to $3,815,000 in Illinois. HCFA calculated the penalties by multiplying the Federal share of the State's Medicaid payments times the State's percentage error rate in excess of its target error

rate. 1/ The following table shows the potential penalties for the April-September 1979 reporting period on the States we visited.

State	Percent over target (note a)	Federal share of program costs penalty is based on (note a)	Estimated penalty
		(000 omitted)	
Illinois	1.8	$217,000	$3,815
Louisiana	.2	69,000	155
Oklahoma	.6	94,000	539
Tennessee	2.2	42,000	921
Washington	.4	65,000	232

a/These numbers are rounded.

From the States' perspective these penalties are quite severe. In effect, the States would be returning Federal funds already spent and, therefore, would have to come up with additional State funds to make up the difference. The alternative of reducing current Medicaid costs may not be very viable because sufficient costs to offset lost Federal funds must be made in a relatively short time. For example, Illinois would have had to cut about $7.6 million in costs to save the necessary $3.8 million in State money and would have had to do so before the end of the State's fiscal year if it were to stay within its State appropriation.

The potentially severe penalties give States an incentive not to cite errors. This in turn can hinder MQC from accomplishing its purpose of identifying and correcting program weaknesses. For example, part of the potential value of the MQC system is in identifying erroneous payments that result from misinterpreting State and/or Federal regulations and policies. MQC can be effective in resolving difficult policy areas only if errors are cited and dealt with in the corrective action program.

For example, Illinois and HCFA MQC reviewers could not agree on how to calculate the amounts that some individuals were supposed to pay toward their own medical care to make them eligible for Medicaid. Illinois has an estimated 56,000 Medicaid recipients whose eligibility depends on their sharing in the cost of their own medical care. The Federal regulations covering these types of cases

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1/The Federal share of Medicaid payments for ineligible SSI recipients is not included in the penalty calculations for States which have an agreement with the Social Security Administration to accept all SSI recipients as eligible for Medicaid.

require that the individuals' Medicaid eligibility be determined by deducting from their income:

--First, the cost of maintenance (food, shelter, clothing, etc.).

--Second, the cost of medical insurance, copayments, deductibles, and health care not included in the State plan as covered Medicaid services.

According to the regulations, the remaining excess income should be applied to the cost of medical assistance items included in the State plan, and only after the excess has been applied is the individual eligible for Medicaid.

The actual procedures followed by Illinois in establishing eligibility for these individuals are to first deduct the cost of maintenance and then establish a collection account payable by the individual to the county. 1/ The individual is declared eligible for Medicaid as soon as the collection account is established. HCFA MQC reviewers were citing all collection cases as errors, reasoning that these individuals would not be eligible for Medicaid until they actually applied their excess income and resources toward health care. State MQC reviewers were resisting HCFA's decisions and not citing these cases as errors, claiming the States' procedures did not violate the Federal regulations because the Federal Government was not participating in any noneligible health costs.

Another disagreement between State and HCFA reviewers involves the issue of when income becomes available to a client. A case in Washington State that we reviewed illustrates this point. On June 5, 1978, the State redetermined a client's eligibility for July 1 to December 31, 1978, using the client's Social Security payment of $248.19 per month as the sole income and arriving at a participation amount of $54.60 per month for a 6-month certification period. The State's quality control review, completed October 11, 1978, verified the computed participation amount as correct. The Federal MQC re-review, however, disclosed that the client had received an increase in SSA benefits effective July 1, 1978, and that the client's July 1978 Social Security check reflected the increase. According to Federal policy, a redetermination should have been made by July 31, and the client's participation increased to $82.56. Thus, the client's liability was understated by $27.96 ($82.56 less $54.60). The State rejected the Federal finding, however, claiming that its review criteria were State written policy and that no State policy had been violated in not calling an error on this case.

1/The Federal Government later receives credit at its Medicaid sharing rate for the total of all collection accounts regardless of whether they are collected.

According to both HCFA and State officials and our observations, many other difficult policy areas exist, such as determining allowable income disregards, the definition of income available to recipients, applicable accounting periods for calculating amounts recipients must pay for medical care from their own income, and the treatment of changes in liquid assets, such as checking accounts, during the eligibility period. Differing interpretations of the requirements related to these policy issues lead to conflicting eligibility determinations by the States and HCFA. In the case reviews, we saw examples of all of these conflicts.

States' MQC reviewers often did not cite errors in such situations. When HCFA reviewers disagreed with the States over policy interpretations, the States resisted HCFA's positions to avoid having errors cited. We believe this resistance tends to slow the data collection process, which in turn slows corrective actions. It may also cause MQC not to identify instances in which unclear, ambiguous, or difficult to administer policy has resulted in questionable Medicaid payments.

Theoretically, the States should react positively to the MQC system and cite all errors because of MQC's long-term potential for producing data that help reduce erroneous payments. However, they have responded to the severe penalties by resisting citing errors and HCFA decisions. This atmosphere disrupts the MQC process because the States and HCFA appear to be constantly disagreeing rather than working cooperatively to identify and solve mutual Medicaid problems.

HCFA STRIVES FOR STATISTICAL ACCURACY TO SUPPORT PENALTIES

HCFA has focused its energy and resources on developing review processes and policies that result in defensible error rates. However, these processes and policies do not identify all errors and program weaknesses, do not allow adjustments of certain administrative errors made by State MQC personnel, and can treat States inconsistently with regard to citing and reporting MQC errors.

HCFA's MQC processes and policies have not been effective in identifying all erroneous payments and program weaknesses. (See pp. 18 to 22.) For example, HCFA uses the State's approved Medicaid plan as the criteria for identifying MQC errors. However, this policy does not permit MQC reviewers to identify certain program weaknesses because some State plans that HCFA has approved include policies and procedures which conflict with the Federal Medicaid regulations. (See p. 36 for an example.) To resolve such conflicts, HCFA and the States must rely on systems other than MQC, and issues can be lost because they are not included in the formal MQC corrective action program. Also, in these instances, MQC can treat States differently with the result that one State's error

rate will include errors for a particular practice while another State's will not.

In attempting to develop unbiased, statistically reliable error rates, HCFA has enforced a policy that will not allow a State to correct clerical errors in its submission of MQC data. For example, in two such instances in Tennessee, the MQC reviewer correctly determined that a recipient listed as eligible in the State's Medicaid records was actually ineligible, but the State inadvertently reported the recipient to HCFA as eligible, incorrectly reflecting the MQC reviewer's decision. However, HCFA would not allow the State to correct its report. The HCFA reviewer reported the case as ineligible, which made the HCFA and State reports differ. The handling of these two cases may have artificially raised the State's error rate because the formula HCFA uses to combine State and HCFA findings into one error rate weights errors reported only by HCFA more heavily than those reported by the State and HCFA.

Even though HCFA devoted its energies to developing error rates to support MQC penalties, it was reluctant to impose severe penalties on the States. When the penalty provisions of MQC became applicable after the April-September 1979 reporting period, HCFA did not enforce them. In addition to the provisions in the regulations allowing the States to apply for a waiver, the Secretary of HHS said the States could show good faith efforts to reduce their error rates and thereby avoid penalties by submitting corrective action plans and having them approved by HCFA. Unfortunately, this emphasis on corrective action plans apparently was an effort not so much to improve Medicaid management as to avoid imposing the fiscal penalties.

We believe that the States' resistance to the MQC program, because of the potentially severe penalties and HCFA's attempts to create defensible error rates to support penalties, may have contributed to inaccuracies in MQC error rate data and to serious weaknesses in the MQC corrective action program. These inaccuracies and weaknesses are discussed in detail in chapters 3 and 4, respectively. Although HCFA and the States have improved both the accuracy of the data and the corrective action program, many problems we observed have not been solved. In our opinion, the potentially severe penalties of the MQC system are a contributing factor preventing resolution of these problems.

BALANCED PENALTIES AND REWARDS SYSTEM NEEDED

We believe that penalties have served a useful purpose in encouraging States to lower their error rates and help maintain a viable MQC program. The States have made improvements in their

Medicaid operations, especially in eligibility administration, that had not been accomplished under other quality control programs without penalties. Thus, we believe the disallowance procedures have had an effect.

However, we believe that reducing the penalties' severity and instituting a positive reward of equal magnitude for good performance is desirable. This balanced approach with both positive and negative incentives would broaden the MQC focus to cover both error rate development and corrective action.

Reducing penalties

The present formula bases the size of the disallowance on the Federal share of total Medicaid payments for health services for cases for which the State determines eligibility (States are not penalized for ineligible SSI cases because HHS makes these eligibility determinations). This can result in program recipients suffering when the State's administration of the program is poor because the State has to find money to fund the program equal to the amount of the penalty and may do so, at least in part, by cutting available benefits. We believe a penalty levied directly against poor administrative performance will more clearly focus on the problem while reducing the severity of the penalty. Many different formulas could be used to apply the penalty to administrative costs. The current formula could be used by applying it only against the State's administrative costs. Thus, the weighted error percentage in excess of the target error rate would be multiplied by the Federal share of the administrative costs. Using the five States in our review that were in a penalty situation as an example, the potential penalties based on administrative costs would be $331,000 instead of $5,662,000. This comparison is shown below for each of the States for the April-September 1979 reporting period.

State	Federal share of administrative costs	Percent error over target (note a)	New penalty	Old penalty
	(000 omitted)		(000 omitted)	
Illinois	$11,100	1.8	$200	$3,815
Louisiana	4,800	.2	10	155
Oklahoma	5,500	.6	33	539
Tennessee	2,900	2.2	64	921
Washington	6,000	.4	24	232

a/ Rounded to the nearest 0.1 percent.

An alternative way to assess a penalty against administrative costs would be to reduce the Federal sharing rate for such costs by a certain percentage for each period the target error rate is not met. The Congress recently took such an action relating to the administrative costs of operating State Medicaid mechanized claims processing and information retrieval systems. If these State systems do not meet prescribed standards, the Federal sharing rate is reduced by 5 percent for each period the State is out of compliance. Using this approach for MQC-related penalties would not, however, relate the amount of the penalty to the extent of excessive errors.

Another approach would be to reduce Federal sharing in administrative costs by a set percentage for each increment by which the State misses its target rate. The following table shows how such a penalty would work if Federal sharing was reduced by 0.5 percent for each 0.1 percent the State exceeds its target error rate.

State	Percent over target	Average Federal sharing rate for State administrative costs	Total administrative costs	Old penalty	New penalty
			(000 omitted)		
Illinois	1.8	.5482	$20,236	$3,815	$1,821
Louisiana	.2	.6252	7,609	155	76
Oklahoma	.6	.5728	9,687	539	291
Tennessee	2.2	.5128	5,663	921	623
Washington	.4	.6164	9,765	232	195

Fiscal incentives

The MQC and AFDC quality control programs and the regulations covering them are similar, but only AFDC quality control rewards good performance. In the Social Security Amendments of 1977 (Public Law 95-216), the Congress established a formula by which States that reduce their AFDC quality control payment error rates below 4 percent can participate increasingly in the Federal share of the money saved. For each 0.5 percent below 4 percent, a State receives an additional 10 percent of the Federal funds saved until its error rate is reduced below 2 percent, when the State's maximum share of the Federal funds saved is 50 percent. This provision became effective during calendar year 1978.

The potential Medicaid savings that would result from cost reductions due to lowered error rates and the rewards for lowering 0.5 percent below the 4 percent target are substantial. The approximate effect of such rewards on the States we visited if

they were to reduce their error rates to 3.5 percent is shown below for the April-September 1979 reporting period. The 4-percent error rate target is apparently achievable because, in the April-September 1979 reporting period, 17 States had rates below 4 percent.

State	Estimated State savings	Estimated Federal savings	Incentive payment
	(000 omitted)		
Alabama	$ 93	$247	$25
Georgia	186	358	36
Illinois	520	520	52
Louisiana	100	239	24
Oklahoma	157	298	30
Tennessee	63	139	14
Texas	518	799	a/80
Washington	154	164	16

a/With an error rate of 3.1 percent, Texas was the only State visited that would have actually been eligible for an incentive payment and would have received this amount.

CONCLUSIONS

MQC's fiscal disallowances designed to encourage lower error rates have not totally achieved the desired results. Their size represents such a potentially severe penalty for missing error rate targets that the States generally have resisted citing errors, often based on their interpretations of HCFA regulations. HCFA's reactions to this resistance and its attempts to ensure defensible error rates have created an adversary relationship between it and the States. The result is a weak corrective action program based on questionable error rate data. A balanced system of fiscal penalties and rewards should remove the impetus behind these problems and create an environment in which the States and HCFA can work together to build a viable MQC system which reduces erroneous Medicaid payments. The penalties and rewards should be of equal magnitude and could be based on administrative costs because administrative errors are what lead to erroneous payments.

MATTERS FOR CONSIDERATION BY THE CONGRESS

To create incentives that will encourage and reward good performance while retaining significant penalties for poor performance, the Congress should consider enacting legislation

--providing fiscal incentives similar to those in the AFDC quality control program for States maintaining low error rates and

--changing the formula for determining Federal fiscal penalties to one which reduces only the Federal participation in administrative expenses.

If the Congress decides against enacting legislation for providing fiscal incentives and reducing the Federal fiscal sanctions, it should consider enacting legislation suspending its directive for Federal fiscal sanctions against the States based on MQC error rates to allow time for HCFA and the States to develop and implement a system free of the weaknesses discussed in this report.

AGENCY COMMENTS AND OUR EVALUATION

In an August 24, 1981, letter, HHS said that its initial reaction to our recommendation to provide fiscal incentives to States with low error rates was favorable but said the issue needs further study. (See app. II.) According to HHS, the data available show that the AFDC incentive provision has had at most a marginal effect on error rates in that program. (See p. 45.) We believe that it would be difficult to determine the impact of the AFDC provision because of the inherent problems in determining what would have happened to AFDC error rates in the absence of the provision. Also, because the reward envisioned is not an additional cost to the Government but merely a sharing with the States of Federal savings, we do not see where our recommendation would be harmful to Federal interests.

In its comments, HHS distinguished between the present practice of assessing disallowances based on the MQC error rate and our recommendation to assess penalties against administrative costs based on this rate. (See p. 45.) Technically, the current method of reducing Federal sharing is a disallowance and not a penalty because it represents a reduction of funds misspent on cases that should not have received payments. However, we believe States perceive the current disallowance formula as a penalty. In any case, the States would lose funds under either method. The semantics surrounding the words "penalty" and "disallowance" should not be used as a justification for using either method.

HHS commented that the disallowance provision and the size of the potential disallowances has focused publicity on State Medicaid administration and the need for corrective action. (See p. 45.) As discussed on page 11, we also believe the potential disallowance has had some beneficial results but, as discussed throughout this report, the size of the disallowances has also impeded the realization of the full benefits of MQC. HHS also commented that, in theory, moving to penalties based on administrative costs implies

that it would disallow funds from States which have poor management. HHS said that, as a practical matter, States would be hard pressed to reduce administrative costs to make up a disallowance and that this could result in worse management and more errors. This argument implies that States would not be hard pressed to make up a larger disallowance of program benefit dollars. As discussed on page 12, we believe errors result from poor management and the best way to focus on this is by reducing Federal sharing in administrative costs.

HHS further commented that, because AFDC's quality control program bases disallowances on program funds, shifting Medicaid disallowance to administrative funds could shift State interest to AFDC with the result that Medicaid, the larger program in terms of beneficiaries and funds, would suffer administratively. Medicaid is indeed the larger program, but this should give the States an incentive to correct errors in Medicaid because the States are spending their funds too. In fact, the States we visited spent almost twice as much of their money on Medicaid as on AFDC during the 6-month period we reviewed.

Regarding the accuracy of the base period data, HHS agreed that there were problems. (See p. 44.) HHS said HCFA had taken prompt actions to improve State and HCFA regional office MQC performance. HHS believes that the accuracy of MQC data has substantially and steadily improved and that the data are fully able to support corrective actions and disallowances. While we trust that the accuracy of MQC data has improved from that of the base period and will improve further when our recommendations are implemented, the current formula for Medicaid MQC disallowances still measures progress in reducing error rates from the base period. To the extent that the base period data are inaccurate--and as discussed in more detail in chapter 3, we found significant inaccuracies--any disallowances made under the formula would be inaccurate. For this reason, we believe that any disallowances calculated using the current formula would not be fully supported.

CHAPTER 3

ACCURACY OF MQC FINDINGS IS QUESTIONABLE

The MQC program's integrity depends on the accurate, unbiased review of each sample case because case findings are used to compute error rates for measuring States' progress in reducing errors, to develop effective corrective action programs, and to impose fiscal sanctions for unsatisfactory progress. However, HCFA and State findings and the resulting error rates are questionable because some case review findings are inaccurate, based on incomplete data, and/or are not independent of other reviews.

We reviewed cases in five States and found $5,000 in paid claims that neither the State nor HCFA had identified. We also found over $6,000 spent in error that neither identified. This failure to identify all applicable claims and errors is significant because errors of only $50 in the sample cases often project to more than $35,000 in erroneous State Medicaid payments per year.

The correctness of the MQC findings for many sample cases reviewed is doubtful because of weaknesses in HCFA's and the States' MQC case review processes, which negatively affect the validity of the case findings and, thus, the error rates.

CASE REVIEW PROCESS

Monthly, each State examines a sample of its certified Medicaid-eligible cases. Nationally, the sample is about 78,000 semiannually with each State having a prescribed minimum sample size reflecting its Medicaid caseload. In most States the Medicaid population is divided into three strata: AFDC, SSI, and Medical Assistance Only. 1/ MQC review cases are selected from the total Medicaid recipient population stratified accordingly.

The MQC reviews proceed as follows: first, the reviewers verify the eligibility of all case members for the review months and identify potential third-party liability. HCFA MQC guidance directs reviewers to determine and document the eligibility of beneficiaries through case reviews and field investigations. MQC normally reviews only the eligibility for the Medical Assistance

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1/Some States do not automatically grant Medicaid eligibility to SSI recipients because they impose more restrictive eligibility requirements than does SSI. In these States, SSI recipients who are also eligible for Medicaid are included in the Medical Assistance Only stratum, and there is no SSI stratum.

Only stratum, 1/ but MQC reviews all three strata for claims processing and third-party liability.

Next, reviewers check Medicaid claims submitted for health services provided during the sample month on all individuals included in the sample cases. They review claims in each sample case for (1) correctness of the claim, (2) possible duplication of claims, (3) correctness of the amount paid, (4) approval of the provider by the State to furnish Medicaid services, and (5) third-party liability.

HCFA selects a subsample of each State's sample and re-reviews the cases, and the claims associated with them, using the same methods the State is required to use. This subsample re-review is designed to validate the accuracy of State quality control determinations. The results of HCFA's re-review are combined with the State's results by use of a statistical formula to produce the error rates. HCFA's results are given more weight in the formula than the State's results.

Semiannually, following computer analysis of data from the sample cases, HCFA's Bureau of Quality Control reports a case error rate and a payment error rate for each State. Because the sample is representative of the total caseload, information obtained from the sample can be projected to the State's universe of Medicaid cases and payments. By analyzing the causes of errors in the sample, the States and HCFA can plan how to avoid similar errors in other cases.

MQC ERROR RATES ARE BASED ON INACCURATE CASE FINDINGS

To verify the accuracy of the MQC program's reported findings, we reviewed the State and HCFA determinations on 982 cases 2/ in Alabama, Georgia, Louisiana, Oklahoma, and Washington. These cases were the HCFA subsample of eligible cases for July, August, and December 1978 in all five States plus the September 1978 cases in Alabama. Before our review both State and HCFA reviewers had examined the cases. In its reviews HCFA identified errors that

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1/The AFDC and SSI programs have their own quality control programs in which they review eligibility, and these eligibility determinations are accepted by MQC. However, in States which do not have an agreement with the Social Security Administration for it to determine the Medicaid eligibility of SSI recipients, the States' MQC reviewers must review SSI cases for eligibility also.

2/A case can include more than one recipient; for example, a case could consist of an elderly couple.

the State MQC reviewers missed. Below we discuss our findings relative only to HCFA's results so the errors we are reporting were missed by both the State and HCFA reviewers. Although most cases were worked correctly, we found that the States and HCFA failed to identify a significant amount of dollar errors and to examine a significant number of paid claims applicable to these cases.

Eligibility errors not identified

We identified additional eligibility errors totaling $2,242 in Alabama and Washington as summarized in the following table. Also, we identified more paid claims in Washington than MQC reviewers had. (See pp. 21 and 22 for a discussion of this problem.)

	Erroneous Medicaid payments due to ineligibility as identified by		Total Medicaid payments of sampled cases as identified by	
	HCFA	GAO	HCFA	GAO
Alabama	$ 331	$1,377	$25,583	$25,039
Washington	1,162	2,358	4,760	5,227

In both States, the MQC reviewers incorrectly reported recipients as being eligible because the reviewers either had applied incorrect MQC policy or had not included certain applicable income.

In one case, for example, the reviewers considered a recipient eligible because they incorrectly applied a provision in the law that individuals who were eligible for Medicaid in August 1972 would not lose their eligibility because of the 20-percent increase in Social Security old age, survivors, and disability benefits which took effect in September 1972. The person lost this eligibility protection of the law when she began receiving increased Social Security benefits upon her husband's death in 1973. However, she continued to be eligible for Medicaid because she was receiving nursing care at home and was able to deduct sufficient medical expenses to reduce her income to the Medicaid eligibility level. For the MQC review month, she was ineligible for Medicaid because she was no longer receiving the nursing care. Both the State and HCFA applied the 1972 policy and erroneously concluded that she was eligible. State and HCFA MQC officials agreed with our finding that she was ineligible.

Also, in several instances MQC reviewers incorrectly calculated the amount that recipients in nursing homes had to pay toward their care from their own income. In most cases the reviewers either failed to include a recipient's total income or made mathematical errors in computing the recipient's liability. Interestingly, the State and HCFA MQC reviewers often made the

same mathematical errors as the eligibility workers when they worked the case. Apparently the reviewers were merely copying the eligibility workers' files. This emphasizes the need for independent MQC reviews. (See p. 23.)

Claims processing errors not identified

State and HCFA MQC reviewers in all five States failed to identify claims processing errors totaling $3,327. The table below shows a comparison of the claims processing errors identified by HCFA MQC reviewers and by us.

State	Claims processing errors identified by HCFA	Claims processing errors identified by GAO
Alabama	$ 4,292	$ 6,729
Georgia	661	739
Louisiana	14,305	14,685
Oklahoma	43	79
Washington	58	454
Total	$19,359	$22,686

Among other things, the MQC reviewers failed to identify services which were not covered and improperly completed claims. For example, in Washington we identified a paid claim for tuberculosis treatment rendered in a general hospital. This type of service is excluded under the State's Medicaid plan and resulted in a $396 claims processing error.

In other cases the reviewers had not identified improperly completed claims. Many States require the provider's and/or recipient's signatures on each claim or provider invoice to help prevent and detect fraudulent claims; however, some MQC reviewers failed to report errors on claims which required, but did not contain, these signatures while others reported them. This inconsistent treatment of errors tends to invalidate reported MQC error rates.

Third-party liability errors not identified

We found additional third-party liability errors in two States. In Washington HCFA reviewers found $48, and we found $832, or $784 more. In Alabama HCFA reviewers found no errors; we found $19. These errors were instances in which we could confirm that the available third party, usually an insurance company or Medicare, would have paid the claims. In addition, we found another 28 cases with potential third-party resources which the MQC reviewers did not identify. In nine of them we identified

over $2,900 in potential liability, but we did not confirm that the third party would have paid. The MQC files did not contain sufficient information on the other 19 cases for us to determine the amount of the third-party liability.

Effect of errors

Although we did not determine the precise effect that our findings would have on the published error rates or estimated erroneous payments, it would be significant because the MQC sample of about 7,000 cases in the five States examined is relatively small when compared to the total universe of about 1 million cases. The total dollar amount examined by MQC is also small in relation to total payments. During the July-December 1978 period for which we reviewed cases, MQC in the five States examined less than $1 million of about $364 million in claims paid by the States during that period. Therefore, even small dollar inaccuracies can affect a State's error rate and dramatically affect estimated erroneous payments. For example, a $50 eligibility error in the Medical Assistance Only stratum identified by Alabama's MQC reviewers for the April-September 1979 period makes less than a 0.1-percent change in that State's error rate. However, that small error is projectable to over $35,000 in total Medicaid dollars misspent during a year. A similar error found by HCFA would have an even larger impact. Clearly, the additional $1,046 in eligibility errors we found in Alabama would have a major impact. Likewise, small errors in other States have similarly dramatic effects.

Inaccuracies in one State also can affect the error rate reduction targets for other States. The weighted average of all base period eligibility error rates determined, in part, the error rate reduction targets for all States. Therefore, the inaccuracies we found in the base period cast doubt not only on the accuracy of error rates in those States, but also on the error rate reduction targets for other States.

Claims not reviewed

State and HCFA reviewers did not examine all applicable claims paid during the review month. Using HCFA's criteria for determining which claims should be reviewed, we identified $130,421 in paid claims for the 982 sample cases reviewed. This was 4 percent more than the $125,316 identified by the HCFA reviewers. The States and HCFA agreed with our findings. The table below shows the claims identified by HCFA and by us. These omissions are significant because HCFA uses the total dollars examined along with the proportion of them paid in error to determine the State's error rate. Unless all applicable claims are identified, there is no assurance that the error rate accurately reflects the proportion of a State's Medicaid claims that are paid erroneously.

State	Paid claims reviewed by HCFA	Paid claims reviewed by GAO
Alabama	a/$ 35,791	a/$ 35,310
Georgia	20,770	20,774
Louisiana	33,663	36,351
Oklahoma	a/13,744	a/13,703
Washington	21,348	24,283
Total	$125,316	$130,421

a/In addition to missing some claims that they should have reviewed, both HCFA and State MQC reviewers included some claims in their review which they should not have, according to HCFA guidelines. This accounts for our totals being lower than HCFA's.

The State and HCFA reviewers had missed claims in all five States, but the problem was particularly severe in Washington and Louisiana. In Washington, we found an additional $2,935 in paid claims, or 14 percent more than HCFA and State reviewers. One cause for reviewers missing claims in Washington was that some recipients were listed under two or more identification numbers in the State's computerized data base system, and MQC only reviewed claims under one number. Of the 112 cases examined for additional claims, we found that 11 had additional claims totaling $733. State and HCFA MQC officials were not aware that some recipients could have more than one number until we identified the problem.

In Louisiana, we found an additional $2,688 in paid claims, or 8 percent more than HCFA and State reviewers. Among other reasons, several of these claims were missed because of clerical errors in the State's procedures for collecting claims.

OTHER CASE FINDINGS ARE QUESTIONABLE

In addition to actual errors in case reviews, several weaknesses in the MQC system cast doubt on the accuracy of many other case findings and thus on the error rates. These weaknesses include lack of independent HCFA reviews, insufficient information on cases to make sound decisions, and the States' prior knowledge of HCFA subsample cases. Due to the nature of these system weaknesses, we were not able to identify specific dollar errors in our findings. Nevertheless, the problems are extensive enough to make some States' error rates questionable and to have limited the effectiveness of corrective action programs.

Lack of independent review

To insure accurate and complete determinations and to identify deficiencies in States' MQC operations, the MQC guidance for HCFA reviewers directs that HCFA's MQC claims processing reviews be made independent of the States' reviews. However, HCFA reviews are rarely independent because its reviewers depend on the State MQC staff to develop the documents necessary for the HCFA review. HCFA generally uses the information in the States' MQC worksheets and rarely attempts to independently collect paid claims or source information. Thus, the HCFA reviews can be no better than the quality of the State-provided documents. In fact, we identified only eight cases, or less than 1 percent of the cases that we reviewed, in which the HCFA reviewer had made contacts to obtain data that the State had not obtained. When we made such contacts, we obtained substantially more data.

Consequently, HCFA reviewers made determinations based on incomplete information and overlooked errors during their MQC reviews. For example, HCFA overlooked some paid claims in Washington because they examined only the claims that the State reviewers examined. The regional MQC chief's explanation for not having found these claims was that HCFA was dependent upon the State MQC to get together all paid claims for HCFA to review. HCFA reviewers did not attempt to understand the State's system for identifying claims for MQC review, nor did they attempt to independently identify the claims requiring review. One of the claims that HCFA missed involved $396 paid for tuberculosis services not covered by the State's Medicaid plan. (See p. 20.) In another example, HCFA reviewers missed seven dental claims totaling $93 for one case in Alabama. Of this amount, $21 was paid in error.

Insufficient information

State and HCFA MQC reviewers often based their case findings on information insufficient to make an accurate decision. In numerous instances MQC reviewers made eligibility determinations without following up on leads concerning possible recipient income and assets.

HCFA reviewers generally begin their eligiblity reviews by examining the case file and findings of the State MQC reviewer instead of first examining the State eligibility file prepared by the case worker to independently determine the extent of verification necessary to substantiate eligibility. By examining the State's MQC findings first, the HCFA reviewers reduce their ability to make an independent judgment on the case. HCFA reviewers should first determine the verification and fieldwork needed and then determine if the State MQC files show that this work was done. This approach to eligibility re-reviews would improve HCFA's ability to detect and follow up on insufficient State eligibility examinations.

In Oklahoma, for example, the MQC reviewers failed to obtain sufficient information on 76 percent of the cases we reviewed. The areas where sufficient information was lacking included the following:

--Employment histories were not documented and current employers were not contacted to verify recipient reported income.

--Private insurance coverage was not determined.

--Copies of divorce decrees were not obtained.

--Potentially available resources were not verified.

--The circumstances surrounding the recipient's disability were not disclosed.

--Military service histories were not included.

Illustrative of insufficient case information in Oklahoma is a case involving an individual who was paralyzed in an accident and later placed in a nursing home as a Medicaid patient. The case file for this individual contained no information to show whether the individual was eligible or potentially eligible for workers' compensation or whether some other third-party payer (i.e., insurance or individual) might have some liability in this case. HCFA officials agreed that the information in the file was insufficient for determining the individual's eligibility or liability and that HCFA reviewers should have obtained information to answer these and other questions which could affect eligibility.

In Alabama, reviewers made decisions without verifying that pertinent information was recorded correctly in the State's computer system. For example, the State's computer adjusts the amount paid nursing homes for Medicaid recipients by deducting the amount the recipient must pay from the institution's billed amount. To prevent erroneous payments, the computer must contain the correct recipient liability; however, MQC reviewers did not verify this information. We found three errors totaling $31 because of this weakness, and because they had gone undetected for some months, Alabama had overpaid the nursing homes over $100. Although we identified only three errors, we expect that many others exist because MQC cases are a statistical sample and, therefore, are representative of the universe of cases.

Sometimes MQC reviewers also failed to pursue third-party liability leads. In Washington, for example, we identified 25 cases with potential third-party resources. In six of these cases we identified an additional $2,800 that neither the State nor HCFA reviewers had pursued.

Another potential problem relates to provider billing mechanisms. Instead of submitting paper invoices, Medicaid providers may, at their option, submit their bills directly to the State Medicaid program's computer by a computer terminal, computer tape, or other electronic device. HCFA's MQC manuals effective in January 1979 directed HCFA MQC reviewers to compare electronic billings to the hard copy claim to verify that the billings accurately reflect services provided. 1/ However, none of the HCFA regions visited were conducting these verifications even though the eight States estimated they make from 7 to 50 percent of their total Medicaid payments based on electronic billings. Georgia, for example, estimated that almost 50 percent of its total Medicaid expenditures are paid through such billings. HCFA officials told us that they were aware of this requirement, but they had not complied with it because of the press of other priority work. In addition, none of the State MQC organizations we visited examined these billing systems.

Prior knowledge of HCFA subsample cases

The intent of the HCFA re-review is, in part, to test the quality of the State reviews and to adjust the State-determined error rate accordingly. This is accomplished by more heavily weighting HCFA-identified errors not found by the State. The presumption is that the re-review is a sample of the State sample and that there are similar undetected errors in the rest of the State sample. Special State attention paid to and more thorough State review of only the re-review cases reduces HCFA's ability to make inferences about the existence of undetected errors in the rest of the State sample. To prevent this, HCFA instructs its reviewers not to identify the subsampled cases to the State's MQC reviewers.

However, to facilitate Georgia's claims processing and third-party liability reviews, HCFA regional officials give the State MQC unit a partial list of its subsample cases. According to HCFA officials, these lists facilitate the State's MQC review and prevent HCFA from missing its deadline. HCFA had given the

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1/In commenting on the report, HHS said this requirement has been deleted because it was beyond the scope of the MQC program.

State such a list as recently as November 1980. This prior knowledge probably caused the reviewers, intentionally or unintentionally, to treat the cases in a special manner by being more thorough with the subsample cases. The State's MQC unit's director told us that, although the State MQC reviewers did not intentionally treat the subsample cases differently, knowing which cases were in the HCFA subsample probably subconsciously affected each State reviewer's effort. A State official in another HCFA region told us that similar instances have occurred in other States.

Furthermore, State's claims processing and third-party liability determinations are potentially prejudiced because States can know in advance which cases will be included in the Federal subsample. HCFA often requests the State MQC eligibility review case files before the State begins its claims processing and third-party liability reviews. This results because State MQC eligibility reviews can begin as soon as the case is selected, but the other two reviews cannot start until 6 months after case selection. 1/ HCFA requests the case files before 6 months to enable its MQC reviewers to complete their work within the time permitted by the MQC semiannual cycle. This prior knowledge of subsample cases could result in these cases being treated specially by the State.

CONCLUSIONS

MQC reviewers correctly worked most of the cases we examined, but we found enough errors, unreviewed claims, and questionable practices (including lack of independence) to cast doubt on the accuracy of the base period error rates. Because the MQC system deals with relatively small samples of cases, even one case incorrectly reviewed can potentially have a significant effect on a State.

RECOMMENDATIONS TO THE SECRETARY OF HHS

To assure that HCFA subsample reviews are conducted independently from the State reviews, we recommend that the Secretary direct the Administrator of HCFA to require that HCFA MQC reviewers determine the extent of verification necessary for a case before examining State MQC files. Also, the Administrator should reemphasize the need for HCFA MQC reviewers to follow established procedures designed to assure independent HCFA re-reviews.

1/The lag period is provided to permit health service providers time to submit claims for services rendered during the sample month and for the State to process these claims.

AGENCY COMMENTS AND OUR EVALUATION

HHS commented that, although in concept independent eligibility reviews may appear meritorious, actual practice proves otherwise. (See p. 46.) According to HHS, a completely independent review, in which its reviewers would reinvestigate and reverify the entire case, is inappropriate. We did not advocate a total reinvestigation of cases. As discussed on page 23, we believe the HCFA reviewers should first look at the eligibility case file and determine which items need to be verified. Then the HCFA reviewer should look at the State MQC file to determine if the State had done all the identified needed verifications. Only if the State failed to do a needed verification or had inadequately done so would the HCFA reviewers perform the verification themselves. By handling reviews in this manner, there would be more assurance that all needed verifications were done and that the HCFA reviewers were not biased by the State reviewers' work. Nothing in HHS' comments indicates that this would not be the preferable sequence for HCFA reviewers.

In its comments HHS agreed that MQC reviewers and management staff should follow established procedures in conducting MQC reviews. (See p. 46.) It pointed out a series of actions it has taken to correct procedural errors in its reviews. HHS said that, for the two examples cited in the draft report, corrective actions had been or will be taken. For the first of our examples, HHS correctly pointed out that the issue of independently collecting and reviewing paid claims in the claims processing review will be eliminated when HCFA implements our recommendation to review claims processing based on an independent sample of claims paid and separated from the eligibility case review. HHS' comments indicated that implementation would begin in October 1981. For the second example, HHS said that HCFA had dropped the requirement to verify electronic billings because this was considered beyond the scope of the MQC review.

CHAPTER 4

MQC SYSTEM HAS NOT FOCUSED ON CORRECTIVE ACTION

HCFA and the States have neglected the corrective action program. First, the program lacks clear direction and leadership. Both authority and responsibility for the program are dispersed among various HCFA and State offices with no one office designated to coordinate corrective action efforts. Second, HCFA and the States have focused nearly all their resources and attention on data accumulation for developing error rates on which to decide fiscal sanctions. Only minimal resources and attention have been committed to or expended on corrective actions to ensure MQC's success as an important tool for improving administration and management of the Medicaid program.

This lack of direction for and commitment to the corrective action program has resulted in MQC producing data that are of limited usefulness for corrective action purposes. HCFA and the States have also failed to develop some potentially useful data and to identify significant program weaknesses.

LACK OF EFFECTIVE *DIRECTION AND LEADERSHIP*

MQC corrective action activities lack effective leadership. HCFA has fragmented the corrective action program and dispersed the responsibility, and authority for directing it, among several units throughout the agency without effectively coordinating their efforts. Consequently, the program has become bogged down in inaction and is not as effective as it could be. However, after error rates, which subjected 18 States to the possibility of fiscal sanctions, were published in September 1980, HCFA began to emphasize development of corrective action plans apparently as a way for States to avoid the sanctions.

Responsibility and authority are dispersed

Responsibility for coordinating corrective action activities at the Federal level is shared between two HCFA bureaus, and the Federal corrective action activities are dispersed among three HCFA bureaus and the 10 regions. Moreover, senior HCFA managers have not clearly defined MQC corrective responsibilities or objectives, and the various competing HCFA units have been left to "negotiate" their responsibilities, spheres of influence, and relationships with one another as far as MQC corrective actions are concerned.

Although HCFA's Office of Quality Control Programs, Bureau of Quality Control, has had overall responsibility for operating the MQC system, its primary focus has been not on corrective actions but on designing and operating a system to accumulate data for developing error rates. In April 1980 the Office of Quality Control Programs and HCFA's Medicare/Medicaid Management Institute in the Bureau of Program Operations entered into a memorandum of understanding which generally outlined responsibilities for directing the corrective action program. Despite this agreement and the general understanding that the Institute has the major role in MQC corrective action activities, the two units' responsibilities for corrective actions apparently remain unclear because they were still negotiating their respective responsibilities as late as December 1980.

The Medicare/Medicaid Management Institute had attempted to develop comprehensive HCFA-wide corrective action strategies aimed a providing overall direction to HCFA's corrective action program. However, the Institute has to negotiate with various HCFA bureaus which are responsible for implementing the individual strategies, and negotiations had not been completed as of December 31, 1980.

In the Atlanta and Chicago HCFA regional offices, corrective action responsibilities were divided between the MQC unit in the Division of Management and a unit in Medicaid's Division of Program Operations. In the Atlanta region these units had no formal understanding of each other's roles, and our discussions with both MQC and program operations officials revealed that the units neither understood the other's responsibilities nor communicated about MQC corrective actions.

The MQC unit in the Dallas region was part of the Division of Program Operations, and MQC corrective action responsibilities were divided between it and the division's State Operations Branch. The responsibilities and functions of each were well defined and directed by the Regional Medicaid Director.

The Seattle region did not have a corrective action program to aid the States in analyzing and correcting errors until late 1980.

Leadership was ineffective

Neither the HCFA central office nor the regional offices we visited have provided effective leadership in developing corrective action programs.

Although the Institute has assumed the major role in coordinating the corrective action program, it had not effectively led the regions in identifying and carrying out their priority corrective action projects. Although MQC began in 1978, the Institute did not become active in the corrective action program

until April 1980, when the HCFA Administrator directed the regions to select and report each quarter the most pressing erroneous payment problems in the States and to focus the region's resources on helping solve them. The Institute is supposed to supply leadership in these projects by analyzing the reports to assure that HCFA corrective action efforts appropriately address priority problems. However, our review of the Institute's analysis of the regions' first quarterly reports on the priority projects showed that the Institute did not adequately analyze the regions' projects or give the regions meaningful critiques of the projects. A responsible Institute official said he was not pleased with some of the projects or the Institute's analysis of them.

HCFA's Office of Quality Control Programs' MQC corrective action responsibilities are to correct problems in the MQC review process and give the States guidance for analyzing errors and preparing corrective action plans, and to give the HCFA regions guidance for evaluating the plans. However, it has not given the States or HCFA regions effective guidance in these areas. The guidance provided for interpreting the meaning of the MQC data is a highly technical manual of statistical formulations, which require rather extensive statistical training to use. However, according to several State officials, some States do not have statistical expertise for using and interpreting the formulations. This probably would be the case in many States with relatively small Medicaid programs. Apparently, the guidance is useful to States which have a staff with statistical expertise capable of making the same analyses of the MQC data without HCFA's manual.

In contrast to its voluminous and detailed guidance on how to collect MQC data, the guidance on how to establish a corrective action program and prepare a corrective action plan is short and sketchy, and provides only generalized suggestions saying little more than "prepare a corrective action plan." HCFA officials agree that more extensive instructions are needed but had not provided them as of February 1981.

HCFA central office has depended heavily on the regional offices to provide leadership to the States for their corrective action programs. Yet, the regions were doing little to aid the States with their problems. Corrective action efforts in the Seattle region primarily centered on changing the MQC system itself. Until fiscal disallowances became a threat, it had not even required the States to submit corrective action plans. Officials responsible for MQC corrective action activities in the Atlanta region were generally not even aware of their responsibilities or of the MQC findings. The Chicago region had obtained corrective plans from only half of its States.

Another example of regional personnel's general lack of involvement in the corrective action process is the regions' failure

to conduct the annual MQC management reviews suggested by the HCFA central office. Of the four regions we visited, Atlanta and Seattle had not conducted them even though an integral part of these reviews is an evaluation of the States' activities in correcting individual errors and in developing a corrective action plan.

Corrective action plans and activities are deficient

HCFA regional officials' lack of involvement in and emphasis on the corrective action program has contributed to weak State programs and correspondingly weak corrective action plans. Washington State did not develop corrective action plans until after it became liable for fiscal sanctions. In addition, Washington did not have adequate systems for assuring that errors identified in sample cases are corrected. Although the MQC unit communicated its findings to other units for correction, neither State nor HCFA MQC officials monitored error correction. In fact, Washington did not analyze its MQC data and did not take corrective actions in response to MQC findings.

The corrective action plans that were submitted to the regions were usually late and reflected weak programs. For example, Alabama's plan covering the base period claims processing errors neither analyzed the error causes adequately nor reported adequate planned corrective actions. It incorrectly reported the claims processing errors as being over 66 percent procedural (which usually do not represent actual misspent Medicaid funds). Actually, the errors were about 57 percent procedural, 29 percent overpayments to physicians, and 14 percent in all other categories. The plan did not explain, and the Alabama officials who prepared it did not attempt to learn, why their claims processing computer frequently paid physicians more than the State allowed, and it did not contain plans to correct this problem. The region did not recognize or question these omissions. Interestingly, the subsequent review period data showed that overpayments to physicians continued to be a significant problem.

HCFA's corrective action section in the MQC manual directs that the States correct individual eligibility case errors and that their recovery unit properly record all identified third-party liability potential. However, State corrective action plans did not address these issues, and we found little evidence that HCFA regional officials were monitoring them. In addition, Washington, Georgia, and Alabama had inadequate systems for monitoring corrective actions.

HCFA has recently begun to emphasize corrective action

During our review, HCFA began to place more emphasis on MQC corrective action. When the error rate data were published in September 1980, the Secretary of HHS informed the States that one means of avoiding fiscal sanctions was to submit an acceptable corrective action plan to HCFA. HCFA's central and regional offices encouraged the States liable for fiscal sanctions to submit plans. While the increased emphasis on corrective action was needed, HCFA's focus on corrective action plans as a means of avoiding fiscal sanctions may reinforce the States' perception that HCFA is preoccupied with the error rates.

MQC HAS FOCUSED ON PRODUCING DATA FOR DEVELOPING ERROR RATES

Instead of focusing on corrective actions, the HCFA central office, HCFA regional offices, and States have concentrated MQC activities on data collection and manipulation. The Office of Quality Control Programs designed the MQC system; developed and updates the manuals; directs technical aspects of sampling, case review, and data processing; and plans for future changes in MQC. It also evaluates the regional MQC units and recommends States for fiscal sanctions based on MQC error rate results. All of these activities are directed at accumulating raw data through the eligibility, claims processing, and third-party liability reviews, and at developing the data into summary error rate statistics. In contrast, this office devotes relatively few resources to the MQC corrective action program and has only limited responsibility for it. The regions' MQC units' activities are directed almost exclusively at developing raw error rate data. In doing this, these units assist the States in their MQC reviews and data processing, re-review subsample cases, and conduct regional MQC data processing functions. The single largest activity of these units is re-reviewing subsample cases. Only the Chicago and Dallas regions' MQC units had devoted perceivable effort to the MQC corrective action program. The Seattle region was doing virtually nothing, and the Atlanta region had limited its corrective action activities primarily to soliciting corrective action plans from the States and making a limited analysis of the plans. In that region the analysis was conducted by the statistician, rather than by MQC managers.

Most State MQC resources are devoted to case reviews and data processing. Each of the MQC units in the eight States we visited estimated that they spent about 90 to 99 percent of their time on case reviews and related activities. This means that 10 percent or less of their time is spent on data analysis or corrective action related activities. In Alabama, for example, two of the MQC unit employees spent only 2 days summarizing and analyzing 6 months of MQC error data and preparing one corrective action plan.

MQC NEEDS TO FOCUS ON PRODUCING BETTER DATA FOR CORRECTIVE ACTION

Because HCFA did not emphasize corrective action, MQC missed some opportunities to produce potentially significant corrective action data. For example, HCFA's policy for selecting a sample of cases and reviewing their paid claims does not assure that a representative sample of the various types of claims is reviewed and results in aged data of questionable value; its method of reporting certain eligibility errors overstates both the actual amount misspent and the potential savings available; its policy of using a State's approved Medicaid plan rather than the Medicaid regulations as the MQC review criteria fails to identify some program weaknesses; and its procedures for examining third-party liability do not extend to determining whether payments are avoided or funds recovered.

We believe that, for MQC to be effective in reducing and eliminating erroneous Medicaid payments and improving Medicaid administration, greater emphasis should be placed on producing better data for effecting corrective action.

Need to sample paid claims for claims processing reviews

Current sampling policy requires States to randomly select sample cases for MQC review from Medicaid eligible recipients. From this sample of cases, MQC determines the accuracy of claims processing for the Medicaid claims paid for health services provided to the recipients of the selected case during the sample month. However, this policy does not insure that the State selects and reviews a representative number of all types of claims paid by the State, especially high dollar claims. 1/ According to Medicaid officials, MQC oversamples some types of claims while undersampling others. For example, they reported that the sampling policy was producing too many low dollar drug claims for review and not enough large dollar claims for other Medicaid services.

In the eight States in our review, drug claims payments range from about 3 to 13 percent of the total States' Medicaid payments. MQC reviewers in several of these States estimated, however, that

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1/A relatively small number of Medicaid recipients receive high dollar value services, such as nursing home and inpatient hospital services. Because the sample cases are drawn from the universe of all Medicaid eligibles, reviewing the claims paid for the sample cases does not assure that the number of high value claims reviewed is relative to their importance on a total Medicaid dollars paid basis from the claims processing and third-party liability standpoint.

they were spending up to 50 percent of their time reviewing drug claims. Based on these estimates, reviewers may be spending only 50 percent of their time reviewing a sample of claims representing 87 percent or more of the States' Medicaid payments. In addition, MQC officials said that claims for some services (for example, durable medical equipment and home health services) rarely appear in their MQC sample claims; therefore, any payment problems related to these services may never be detected by the MQC reviewers.

If MQC's sampling requirements were changed so that, for the claims processing and third-party liability reviews, a sample of claims paid during the review month was selected, there would be more assurance that a representative sample of paid claims would be reviewed. Paid claims could be stratified by type of service to assure that enough claims for each type were reviewed to identify any claims processing or third-party liability problems associated with each type of service. Under such a scheme, two samples would be drawn--a sample of cases for eligibility review and a sample of paid claims for claims processing and third-party eligibility review.

Also, HCFA's sampling policy systematically excludes claims for retroactive cases from the MQC review process. Retroactive cases are those in which eligibility for Medicaid is certified retroactively for up to 3 months before the date of application for Medicaid and health services bills incurred during the retroactive period are eligible for payment under Medicaid. Because only current active cases make up the sample universe, claims for retroactive cases are never reviewed. Although we did not determine what portion of States' Medicaid payments are for retroactive cases, we were advised by State officials in Georgia, Illinois, and Oklahoma that such cases account for a significant portion of Medicaid payments.

Need for more timely data to correct problems

MQC claims processing data are at least 6 months old before they are available for review and analysis. Before being included in the State's corrective plan, some data may be as much as 18 months old, which significantly reduces their value for corrective action purposes. This delay is necessitated because of HCFA's policy to review the same sample cases for eligibility and paid claims. The State MQC reviewers, therefore, must wait until claims for medical services provided during the sample month are submitted to and paid by the State before beginning the claims processing reviews. Six months, including the month of service, are allowed for claims to be submitted, paid, and adjusted. Furthermore, corrective action plans are required only annually; therefore, claims processing data included in such plans may be as old as 18 months.

The delay in reviewing claims has led to at least one ridiculous situation. Alabama changed fiscal agents half way through one reporting period, but for 6 months MQC continued to review claims paid by the former fiscal agent. Several effects followed. First, identifying errors made by the former agent had little value in helping improve the current fiscal agent's system. Second, MQC could not begin testing the new fiscal agent's system for over 6 months after it began paying claims. Third, the error rates for two reporting periods combined the results of two fiscal agents and did not truly reflect the current status of the State's payments system. The new fiscal agent and State officials tended to dismiss the claims processing error results as not being a reflection on the new agent for almost a year after it began operations in the State.

If a separate claims processing sample were drawn from the universe of claims paid during the review month as suggested in the previous section, MQC review could begin immediately and would not have to wait 6 months. Thus, the results would be available and corrective action instituted much sooner. For example, claims paid in July could be reviewed in August and, if the results uncovered a computer processing error, corrective action could be started immediately. Under current conditions, claims for services provided in July (which could be processed anytime from July through November) are not reviewed until January of the next year, and up to 6 months of erroneous payments could be made before the problem is identified. Of course, summary statistics for the 6-month period and the required formal corrective action plan would not be speeded up, but we believe States will act on the kinds of situations discussed in the example as soon as they are identified and not wait until the formal corrective action plan is prepared.

Need for accurate reporting of program losses due to ineligibility

HCFA's procedures for determining and reporting MQC results overstate both true program losses due to ineligibility and potential savings available from correcting certain eligibility errors. As we pointed out in our 1978 report about Ohio's Medicaid program, 1/ HCFA uses procedures that do not distinguish between technical and substantive eligibility errors. One example is MQC's treatment of situations involving excess personal resources. The requirements result in a high incidence of technical and temporary ineligibility--technical because an eligibility requirement is often exceeded only by a nominal amount, and temporary because, once realized and adjusted by the recipient (by disposing

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1/"Ohio's Medicaid Program: Problems Identified Can Have National Importance" (HRD-78-98A, Oct. 23, 1978).

of excess resources), the discrepancy does not result in the recipient losing his or her Medicaid eligibility. Such situations frequently occur with the $25 monthly personal allowance for institutionalized recipients. Frequently, the recipient does not spend this allowance, and it is accumulated and maintained by the institution. Within a few months the recipient's personal allowance can result in him/her exceeding the liquid asset limits for Medicaid, causing technical ineligibility for further benefits. Spending the excess amount restores eligibility.

In these situations the computations of program error rates and related dollar losses can be misleading because the total amount of the claim is used in computing dollar loss, instead of the amount by which resource limits are exceeded. In addition, any projection of potential savings from eliminating these eligibility determination errors will be overstated. We reported that, of MQC's estimated erroneous payments for Ohio of $34.4 million during a 6-month period in 1976, at best $15.2 million could be saved by Medicaid by eliminating all errors. Clearly, HCFA's calculation of misspent dollars complicates the State's cost/benefit analyses of planned corrective actions.

Need for review criteria that identify all program weaknesses

HCFA's policy of using a State's approved Medicaid plan rather than the Medicaid regulations as the criteria for identifying MQC errors does not permit MQC reviewers to identify and report all program weaknesses. This occurs because some State plans that HCFA has approved include policies and procedures which conflict with Federal Medicaid regulations, and these conflicts are not identified and targeted for corrective action through the MQC system. For example, HCFA's interpretation of the Federal regulations is that resources exceeding the eligibility level must be liquidated before Medicaid eligibility can be established. As many as 12 States (including Illinois and Louisiana, which we visited), however, do not require that the resources actually be liquidated but allow health care expenses incurred to be counted as liabilities against excess resources even though such resources may never be actually spent. HCFA does not cite these situations as MQC errors because it erroneously included in the preprinted plan form an option which permits this procedure. HCFA has approved these plans. On the other hand States would be cited for MQC errors if they are allowing individuals to offset and not liquidate their excess resources but failed to check this option in their State plan.

By not using the Federal regulations as the ultimate review criteria, HCFA must rely on systems other than the MQC system to identify, report, and resolve those problems. In addition, MQC can potentially treat the States differently for following

essentially the same practices because one State includes an erroneous practice in its State Medicaid plan while another State follows the same practice but does not include it in its plan.

Need to expand MQC to cover third-party liability recovery

The third-party liability system has two basic activities: identifying potential third-party resources and utilizing those resources through either cost avoidance or payment recovery. Both are vital; however, MQC directs its primary effort at identifying and confirming liability on the part of third parties. Although the MQC procedures for identifying liability were weak and produced data of limited value, recent changes have improved those identification efforts.

On the other hand, MQC does not examine in any depth, nor does it have plans to examine, the effectiveness of the resource utilization or recovery effort. Although the MQC manual standards for confirming liability are rigorous, the standard for determining resource utilization and recovery is weak. For example, the MQC manual cites as acceptable evidence for resource utilization or recovery such "[c]orrespondence from the State to the beneficiary requesting information on the specific third party resource or casualty situation that the [M]QC reviewer has identified. * * *" This action, in our opinion, does not constitute even a reasonable effort at third-party liability recovery, much less acceptable evidence of actual recovery. We, therefore, believe that the MQC system should be expanded to include verification of actual recovery or utilization of third-party liabilities.

CONCLUSIONS

HCFA has not provided effective leadership or clear direction for the MQC corrective action program. Consequently, it is not as effective as it could be. HCFA has devoted its resources to designing and implementing a data collection system to support fiscal penalties while largely ignoring the corrective action program except as a means to avoid disallowances. As a consequence, the data produced from the MQC system have been of limited value to States in their corrective action programs because

--the claims processing data are outdated before they are available and do not report problems on some types of claims;

--claims paid because of retroactive eligibility are never reviewed;

--the eligibility data overstate the potential savings from correcting errors and thus complicate the corrective action process; and

--the review criteria do not identify all program weaknesses, and the third-party data do not evaluate States' third-party recovery efforts.

To overcome these weaknesses HCFA must emphasize the importance of the MQC corrective action program by providing effective leadership and assistance in developing strong State programs.

Also, we believe HCFA needs to modify its MQC procedures to base the claims processing and third-party liability reviews on a sample of paid claims. This should provide more useful and timely data for corrective action purposes as well as assure that a representative sample of claims are reviewed. The MQC procedures also need to be changed so that information is reported on the potential savings available from eliminating eligibility errors and to provide that the Medicaid regulations are the ultimate review criteria in order to assure that all types of Medicaid administrative problems are resolved by MQC.

RECOMMENDATIONS TO THE SECRETARY OF HHS

To improve HCFA's administration of the MQC corrective action program, we recommend that the Secretary direct the Administrator of HCFA to

--designate within HCFA central and regional offices clear responsibility for and authority to carry out the MQC corrective action program and

--issue a corrective action manual for assisting the States in developing strong corrective action programs.

To enhance MQC's ability to facilitate corrective actions, we further recommend that the Secretary direct the Administrator to improve MQC procedures by

--selecting the MQC claims processing and third-party liability sample from the universe of claims paid during the review month, including claims paid for retroactively eligible cases, which would separate the claims processing sample from the eligibility sample;

--changing the method of reporting MQC errors to include estimates of the potential savings available from eliminating Medicaid eligibility determination errors;

--adding an evaluation of the States' third-party recovery efforts to MQC review; and

--making the ultimate criteria for determining MQC errors the Federal Medicaid regulations instead of the States' Medicaid plans when the two are inconsistent.

AGENCY COMMENTS AND OUR EVALUATION

HHS agreed with our recommendation that there be a clear designation of responsibility and authority for carrying out the MQC corrective action program at the central and regional offices. (See p. 48.) HHS' response, however, did not indicate when this designation of responsibility and authority would be made in the regions. Concerning designation of responsibility and authority within the central office, HHS said this responsibility was designated to HCFA's Medicare/Medicaid Management Institute before we completed our review. As we state on page 29, in April 1980, the Office of Quality Control and the Institute entered into a memorandum of understanding which gave the Institute the primary role for MQC corrective action activities. However, this designation of responsibility was merely a formality at that time because the two offices were still negotiating their respective responsibilities as late as December 31, 1980, over 8 months after the memorandum was signed. Also, as discussed on page 29, as of December 31, 1980, because the Institute still was negotiating with various HCFA bureaus having responsibility and authority for implementing corrective action, responsibility and authority remained unclear at the time we completed our fieldwork at the central office in December 1980.

Apparently, HHS misinterpreted our report's discussion of the limited corrective action activities of various HCFA central and regional offices, including the Office of Quality Control Programs, to mean that we believe that these offices should become more involved in corrective actions. Our report does not recommend that the Office of Quality Control Programs or any specific office be given corrective action responsibility; it recommends that there be a central and regional office designation of "clear responsibility for and authority to carry out the MQC corrective action program." Thus, the issue that we raised is not which office, but that there be a clear designation of responsibility and authority for carrying out corrective action activities.

HHS agreed with our recommendation that a corrective action manual for assisting States in developing strong corrective action programs be developed and issued (see p. 49). HHS said that corrective action planning process guidelines and a corrective action plan format for use by the States were already under development. According to HHS, when completed, these guidelines and format will be incorporated into part 7 of the State Medicaid Manual.

HHS agreed with our recommendation that the claim processing sample be separate from the eligibility sample and said that a plan to separate the two was being developed. (See p. 49.) According to HHS this plan, which calls for selecting the claims sample from authorized payment tapes, will be implemented effective October 1, 1981. HHS said that, since the claims processing review is tied to the eligibility review by regulation, this new system for separate eligibility and claims samples will be installed on a waiver basis until regulatory change can be effected. We believe that, when implemented, this new system of selecting and reviewing claims will significantly increase the effectiveness of the claims processing part of the MQC program.

HHS also agreed with our recommendation, which we first made in 1978 (see HRD-78-98A, Oct. 23, 1978), to change the method of reporting MQC eligibility errors to include estimates of the potential savings available from eliminating these errors. HHS acknowledged that current reporting procedures overstate potential savings and agreed to include, in its reports, estimates of potential savings available from eliminating Medicaid eligibility errors. This change, according to HHS, will become effective with the review period beginning April 1982.

HHS disagreed with our recommendation to use as the ultimate criteria for determining MQC errors the Federal Medicaid regulations instead of the State's Medicaid plan when the State's plan is inconsistent with the regulations. (See p. 51.) HHS said that MQC is a State-based system; therefore, HHS reasoned that State criteria (the State plan) should be used by MQC for determining MQC errors even though this criteria may conflict with the requirements of the Federal regulations. HHS agreed that inconsistencies exist between some States' HHS-approved Medicaid plans and the Federal regulations and that MQC has uncovered inconsistencies.

We continue to believe that it makes little sense to use as the ultimate criteria for determining erroneous Medicaid payments criteria that are not consistent with the Federal Medicaid regulations. In our opinion, the program should be redesigned to identify and correct all of a State's Medicaid policies, procedures, and practices that conflict with Federal Medicaid regulations. HHS may be concerned that States will oppose efforts to use the Federal regulations instead of their approved Medicaid plans if this results in identification of additional errors and higher error rates. If this is HHS' concern, we believe that HHS could use the Federal Medicaid regulations as the ultimate MQC review criteria but exempt the additional errors from error rate computations for a specified period to allow a State time to revise its plan and practices.

Concerning our recommendations that third-party liability MQC reviews be (1) selected from the universe of paid claims rather than the eligibility sample cases and (2) expanded to include an evaluation of the States' recovery efforts, HHS' response generally was negative. (See pp. 49 and 51.) HHS believes that third-party liability reviews should be based on eligibility cases because third-party liability leads are obtained during home visits made principally to obtain data on which to determine eligibility. According to HHS, basing third-party liability reviews on paid claims would require additional home visits to individuals included in the claims processing sample but not the eligibility sample. HHS reasoned that this would be an inefficient use of resources. We do not believe that additional home visits would be necessary because third-party liability information obtained during home visits is generally limited to the client's response to two or three simple questions concerning whether the client has insurance and, if so, with what insurance company. We believe that this information could be obtained without a home visit. For example, telephone contacts or questionnaires could be used. Concerning our recommendation to add an evaluation of the States' third-party liability recovery efforts to MQC review, HHS said that it will explore ways to expand the system to do so. However, HHS was silent as to when and how it would do this. Our primary concern in the MQC third-party liability area is that it be expanded to include an assessment of recovery efforts. As currently performed MQC focuses on establishing liability. We believe that establishing liability without assuring that costs are avoided or are recovered is only half the job. Whether HHS chooses to use the eligibility sample or a claims processing sample for third-party liability review is secondary to including an evaluation of recovery efforts.

ELIGIBILITY PAYMENT ERROR RATE

FOR PENALTY LIABLE STATES (note a)

State	July-Dec. 1978 rate	Target rate	April-Sept. 1979 rate
Arkansas	6.8	6.2	11.1
Colorado	3.2	6.2	7.1
Delaware	9.3	7.8	11.1
Florida	2.8	6.2	10.8
Illinois	6.3	6.2	8.0
Iowa	10.1	8.5	11.7
Louisiana	4.1	6.2	6.4
Maine	14.5	12.3	18.7
Maryland	6.2	6.2	6.5
Massachusetts	4.9	6.2	8.6
Montana	10.5	8.9	15.7
North Dakota	1.9	6.2	6.5
Oklahoma	5.8	6.2	6.8
South Carolina	5.3	6.2	7.2
Tennessee	3.0	6.2	8.4
Vermont	5.4	6.2	9.9
Washington	5.0	6.2	6.6
Wyoming	7.7	6.5	8.9
National weighted average	6.2		4.9

a/ Rates exclude cases for which eligibility is determined by the Social Security Administration.

APPENDIX II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

24 AUG 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Medicaid's Quality Control System Is Not Realizing Its Full Potential." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

APPENDIX II

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U. S. GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED, "MEDICAID'S QUALITY CONTROL SYSTEM IS NOT REALIZING ITS FULL POTENTIAL"

Overview

The report accurately indicates certain improvements which will increase the usefulness of the Medicaid Quality Control (MQC) system. Steps are complete or underway to improve the accuracy and timeliness of data collection while also reducing the burden imposed by quality control activities. Specifically, the changes recommended in claims processing review procedures were stated to GAO by Health Care Financing Administration (HCFA) staff during the course of the review and will be implemented by States on a voluntary basis in October of 1981. Mandatory implementation will follow. A revised method of reporting findings to include estimates of potential savings along the lines suggested by the report was announced on July 24, and will be implemented partially in FY 81 and fully in FY 82. We are in the final stages of writing a corrective action manual. We appreciate the recommendations in support of our efforts.

The report contains recommendations to the Congress for revising legislation for disallowances under the MQC program. We do not believe that the report fully substantiates the proposals made. The question of the value and appropriate magnitude of penalties/disallowances will be addressed as part of a comprehensive review of current legislation and Department policy. We anticipate that recommendations from this review will be available during the latter part of FY 82.

We believe the report incorrectly characterizes the substantive and successful corrective action initiatives taken by HCFA over the past 2 years. Corrective action has always been viewed as a principal outcome of quality control. Beginning with the establishment of a special corrective action project team, continuing through specialized action plans submitted by States not meeting error targets (in addition to those regularly submitted by all States) and culminating in more analysis and positive action by both the States and Federal government, there has been a greater focus on improving the management of the Medicaid program than ever before in its history. We would be pleased to participate with GAO in a further analysis of the status and outcome of our corrective action efforts.

The report suggests that the accuracy of the base period finding is not as good as would be desired. The base period was the first review period under the then new MQC program and there were, as expected, review problems. Prompt and prudent actions have been taken by HCFA to improve regional and State performance when problems were noted. The existence of problems in the base period and HCFA's corrective action effort were fully reported to the GAO at the time of the review. We feel that by taking quick action the accuracy of quality control (QC) data has been substantially and steadily improved and data are fully able to support corrective actions and disallowances if required. The relationship of the accuracy of base period findings and its effect on implementation of the "Michel Amendment" will be addressed in a comprehensive review of all disallowance/penalty-related programs.

GAO Recommendation

To create incentives that will encourage and reward good performance while retaining significant penalties for poor performance the Congress should consider enacting legislation:

- providing fiscal incentives similar to those in the Aid to Families with Dependent Children quality control program for States maintaining low error rates;

Department Comment

We believe the issue requires further review.

Our initial reaction to the concept of balancing penalties with incentives is favorable. However, based on the data available, it appears that incentive legislation has had marginal, if any, effect on the reduction of error rates in the Aid to Families with Dependent Children (AFDC) QC program. Before such a legislative change is enacted, a much more thorough analysis of the effects of the action should be conducted.

GAO Recommendation

- changing the formula for determining Federal fiscal penalties to one which reduces only the Federal participation in administrative expenses.

Department Comment

We believe further study is necessary before a definitive position can be taken. The main issue of concern is the effect reducing the amount of disallowances by a measurable degree would have on the corrective action process. Before the imposition of the disallowance regulation, numerous States did not implement the MQC program; before that, the AFDC QC program had the same problem when that program had no disallowance regulation. The disallowance provision has focused publicity on the States' administration and has provided an incentive for the implementation of corrective actions needed to reduce erroneous payments. The amount of disallowance involved has generated publicity which has prompted States to take necessary corrective action. We do not believe that any change should be made in the current procedure for calculating disallowances until a thorough study is performed on the factors influencing the States' motivation to reduce error rates.

We have serious reservations with imposing penalties against Federal participation in administrative expenses rather than assessing disallowances based on program dollars. The quality control disallowance regulations (CFR 431.801 and 431.802) provide for reductions of program costs to disallow misspent federal funds on cases that should not have received those funds. This is a straight disallowance and one which reflects language in section 1903(a)(1) of the Social Security Act providing for Federal matching only in medical assistance payments under the State plan.

APPENDIX II

In theory, moving to administrative costs implies that we would disallow funds from States which have poor management. As a practical matter, States would be hard pressed to reduce administrative costs to make up a disallowance and internal management would be adversely affected, possibly causing an increase in problems which resulted in erroneous expenditures. The reduction of these administrative expenditures could result in even more problems for State management, thereby perpetuating a negative cycle.

Finally, it is important to note that AFDC's QC program disallows funds based on program dollars. If the MQC disallowances applied only to administrative costs, State interest could shift to AFDC since more disallowance dollars would be at risk. Since Medicaid is a significantly larger program in terms of beneficiaries and funds, there would clearly be a negative effect from such a change.

GAO Recommendation

To assure that HCFA subsample reviews are conducted independently from the State reviews, the Secretary of HHS should direct the Administrator of HCFA to require that HCFA MQC reviewers determine the extent of verification necessary for a case before examining State MQC files. Also, the Administrator should re-emphasize the need for HCFA MQC reviewers to follow established procedures, such as independently collecting and reviewing paid claims and verifying electronic billings, which are designed to assure independent HCFA re-reviews.

Department Comment

In concept, independent eligibility reviews may appear meritorious; however, actual practice reveals otherwise. If GAO intends that HCFA MQC reviewers should make an independent judgment of eligibility based on: the State's MQC file; the State's eligibility case file; and follow up investigation, then we would concur. Indeed, this is the review criteria and was the review criteria for the base period. We encourage and train HCFA MQC reviewers to use the State's MQC file to focus the review and determine which elements of eligibility need verification. The eligibility case file should be used to complete the review, gleaning leads on information missed by the State MQC reviewer and identifying any other factors that may affect eligibility.

We do not believe that a completely independent eligibility review is appropriate. To reinvestigate and reverify elements of eligibility already conclusively documented by the State would be a misuse of already scarce Federal resources. Additionally, it would not increase the accuracy of the error rate nor provide any more information for corrective action.

Further, we disagree with the concept of determining the extent of verification necessary from the eligibility case record prior to examining the State MQC file. As explained in the preceding paragraphs, it would be impossible to determine what verification was necessary from the eligibility case file alone since the State MQC reviewer may have already recorded pertinent facts in the State MQC file.

We agree that HCFA MQC reviewers and management staff should follow established procedures in conducting MQC re-reviews. The period reviewed by GAO was the first review period under the new MQC program. We identified numerous problems with the data in this period. While we concur with the basic finding that such problems exist, we

APPENDIX II

are unable to evaluate most of the individual errors noted in the report due to the absence of specific information. However, as problems were identified we responded to them in a prompt and substantive manner. Actions taken by HCFA were briefed to GAO staff; and, copies of our own assessment documents identifying problems and proposing solutions were furnished.

As problems in the conduct of QC reviews surfaced, management took a series of actions designed to meet the situations which we feel have led to the elimination of most of the types of errors found.

- A series of questions and answers has been furnished to each HCFA regional office, responding to technical and management issues raised by them, to ensure national uniformity on the most complex issues of MQC reviews.

- HCFA regional office assessment coupled with follow up visits to assure that recommended actions were implemented was initiated in May 1979 resulting in improved regional office performance.

- Training sessions with HCFA regional office QC supervisors and senior staff are held an average of three times per year to openly discuss policy issues and operations.

- Monthly conference calls are conducted between HCFA central office staff and regional office staff to keep lines of communication open between training sessions and assessments.

- Training packages were developed in areas of common concern and have been distributed to all regional offices.

These management actions, as verified by regional office assessments, have resulted in data being improved in each subsequent period. We are continuing these, as well as other efforts, to assure that data produced in this complex program are accurate and consistent.

The issue of independently collecting and reviewing paid claims in the claims processing review has been rendered moot by the implementation of the independent sampling system for claims processing reviews (MQC II). As the basis and purpose of this system is discussed in response to another recommendation, it will not be discussed further here. It is noted that the independent claims collection process under the previous system did serve its intended purpose because it identified the same types of deficiencies that this report makes evident. In addition to regional office activities, central office has initiated reviews of claims collection processes when necessary.

We do not concur with the recommendation that MQC should verify electronic billings. We must point out that this requirement did not exist in the base period and MQC reviewers accordingly, undertook no such verification. Although the manual did require such verification at one time, the manual has since been revised to delete the verification requirement because it was felt that the verification requirement was not a part of the scope of the MQC review.

APPENDIX II

GAO Recommendation

To improve HCFA's administration of the MQC corrective action program, the Secretary, HHS, should direct the HCFA Administrator to:

- designate within HCFA central and regional offices clear responsibility for and authority to carry out the MQC corrective action program;

Department Comment

We concur. We must, however, point out that at the time of the GAO audit an official designee for corrective action initiatives had already been made within HCFA's central office; namely, the Medicare/Medicaid Management Institute (M/MMI). This component has the lead in monitoring State and regional implementation of corrective action (this function is accomplished through the HCFA regional offices) and in overseeing central office initiatives which can simplify policy and assist States in improving the administration of their Medicaid programs. In addition, M/MMI offers intensive technical assistance to States in the areas of eligibility, third party liability, and claims processing.

While we would agree that more can be done in the area of corrective action, a great deal has been accomplished already. The HCFA regional offices were required to select roughly one area per State in which they could offer the State assistance and to monitor implementation of corrective action in this area. The HCFA regional offices report quarterly on this activity. In addition, corrective action workshops have been held, and State attendance has been high. An MQC/Corrective Action Technical Assistance Group (TAG), comprised of State personnel, was established and has met several times to comment and advise on MQC and corrective action issues. M/MMI has also identified a series of actions that HCFA should undertake to assist States and also monitors HCFA's implementation of these actions.

The report implies that the Office of Quality Control Programs (OQCP) should involve itself more in the corrective action process. We do not concur with this finding. OQCP was designed to administer the ongoing quality control programs within HCFA. It is a basic management tenet that the organization which measures quality should not also be responsible for improving it. Instead, it should supply the information necessary for operations to improve the quality. And that is exactly what OQCP does. The analysis of data is the main contribution OQCP provides to the corrective action process. This division of labor is spelled out in a Memorandum of Understanding (MOU) to which the report refers. That MOU is the final step in a series of actions designed to define and assign responsibilities to prevent overlap and duplication of effort.

The report implies that HCFA has focused attention on corrective action merely to help States avoid fiscal disallowances. This is not the case. When the new MQC system was approved in 1978, 125 positions were assigned to the effort; 35 of these positions were set aside for corrective action. This group immediately began offering and providing technical assistance to States with both high error rates and high program dollars. The initial MQC regulation promulgated in 1978 mandated that all States submit a yearly corrective action plan each July 31. HCFA has monitored the States' submission of this document, as well as the special corrective action plans for disallowance-liable States. While it is true that in recent times the main emphasis has been on the disallowance-liable States, these States generally have the highest error rates. Thus, the concentration of resources on helping them solve their problems makes good management sense.

GAO Recommendation

- issue a corrective action manual for assisting States in developing strong corrective action programs.

Department Comment

We concur and in fact have already done a great deal toward effectuating this recommendation. HCFA staff developed guidelines to be utilized in the corrective action planning process and a format for the formal corrective action plan States are required by regulation to submit each July 31. These guidelines and format were developed in conjunction with the MQC/Corrective Action TAG, and have been sent back to the TAG and HCFA regional offices for final comments. When finalized, the guidelines and format will be incorporated into Part 7 of the State Medicaid Manual.

In addition, HCFA has conducted State/Regional workshops on corrective action and has been active in providing technical assistance on a State-by-State basis. Many States already have strong corrective action programs, and these States' personnel have assisted HCFA in providing this technical assistance to States with weaker programs.

It should be noted that Medicaid is a State administered program, and ultimately it is up to the States to improve the management of their own programs.

GAO Recommendation

To enhance MQC's ability to facilitate corrective actions, the Secretary, HHS, should direct the HCFA Administrator to improve MQC procedures by:

- selecting the MQC claims processing and third party liability sample from the universe of claims paid during the review month including claims paid for retroactively eligible cases, which would separate the claims processing sample from the eligibility sample;

Department Comment

We concur with most of this recommendation.

We agree that claims processing reviews should be performed on a sample from an authorized payment tape. (Authorized payment tapes will be used, rather than paid claims tapes to provide faster corrective action data and to review State payment decisions - the heart of the process.) In fact, plans have been developed over the past year to implement a revised claims processing sample and review beginning October 1, 1981. Claims sampling and review will be separated from the eligibility review and, instead, be selected from authorized payment tapes. All appropriate manuals and action transmittals are in the final stage of the HCFA clearance process.

This system will:

- provide timely data for corrective action;
- provide more accurate data for corrective action;
- provide for more State flexibility in sample design;

APPENDIX II

- provide more targeted information for corrective action;
- provide a better error category profile for corrective action;
- result in national workload reduction when combined with other changes;
- review all paid claims including those for retroactively eligible cases;
- provide a better mix of claims so that provider class rates and high dollar rates can be analyzed; and
- provide a 40 percent reduction in claims reviewed.

This system will be installed on a waiver basis this October, since the claims processing review is tied to the eligibility review by regulation. HCFA is working through the process of regulatory change on this issue. Thus far, the concepts of this system have been pilot tested in two States with 10 additional States seeking waivers immediately.

We would like to point out that the system was carefully briefed to:

- the GAO auditor;
- all States in Information Memorandum 81-08 dated April 1981;
- the American Public Welfare Association;
- the MQC-State Technical Advisory Group;
- the State Medicaid Directors' Conference; and
- the Executive Office of Management and Budget.

Further technical details were provided to State agencies in a series of three regional workshops in July of 1981.

We do not, however, concur with the recommendation to select the third party liability sample from the universe of paid claims, but believe it should still be attached to eligibility reviews. This is because this review requires an initial home visit to elicit third party liability leads. QC reviewers are already making home visits as part of the eligibility reviews. Thus, performing third party liability reviews based on a claims sample is duplicative, requires enormous manpower resources, and does not make efficient use of resources already employed.

GAO Recommendation

-- changing the method of reporting MQC errors to include estimates of the potential savings available from eliminating Medicaid eligibility determination errors,

Department Comment

We concur. However, we do not believe this recommendation is consistent with the recommendation discussed below to review against the Federal regulations.

The issue of what constitutes real savings for the situation referred to in the GAO report has been a difficult one. Over the past year there have been indepth discussions about this issue within HCFA, including the airing of alternative views. MQC was initially designed to measure misspent funds. Misspent funds are defined as payments in which the Federal Government need not participate because of erroneous eligibility determinations, uncollected third party liability, and incorrectly paid claims. The statute and regulations clearly state that beneficiaries with excess resources are ineligible and that spenddown of resources is not allowed. Thus, we counted the full vendor payment for ineligible beneficiaries as misspent in accordance with Federal regulations.

We also realize that the full amount of misspent funds cannot always be saved by correcting a mistake. Accordingly, we are changing our reporting procedures effective with the April 1982 review month to collect both savings dollars and misspent funds.

GAO Recommendation

- adding an evaluation of the States third party recovery efforts to MQC review, and

Department Comment

We do not completely concur with this recommendation. We recently revised our third party liability procedures to make improvements in data collection. From the perspective of evaluating the effectiveness of third party quality control procedures as a management tool, it is important to recognize that overall departmental efforts in this area have been in effect less than 18 months. The system is, therefore, still in the early stages of development and we are implementing changes based on our experience in States to make refinements and improvements. However, at this time these changes have not been in operation long enough for us to evaluate their effect. We will explore ways to expand the system to include recoveries.

GAO Recommendation

- making the ultimate criteria for determining MQC errors the Federal Medicaid regulations instead of the States' Medicaid Plans when there are conflicts between the regulations and the State plans.

Department Comment

We do not concur with this recommendation. MQC is a State-based system operated by State personnel with Federal oversight. The appropriate review criteria is therefore State policy and the approved State plan. The State plan is the contract between the State and Federal Government, and section 1903(a)(1) of the Act provides for payment to the States on the basis of the plan.

APPENDIX II

There have been instances uncovered in the course of MQC reviews of erroneously approved State plan material. This is one of the many contributions made by the MQC system. These conflicts between approved State plans and Federal regulation are promptly addressed through the negotiation or compliance process.

Many instances of either correction of State plan preprint, HCFA policy, or State policy have resulted from the MQC uncovering conflicts between Federal regulations and approved State plans on policy material. MQC errors are not called; however, the issues are addressed and corrected as appropriate. For example, the report cites the spenddown of resources provision erroneously included in the State plan preprint. A revised preprint was furnished to States in August 1980 with an implementation date of September 30, 1980 which deletes the erroneous option.

It is our belief that this quality control system will be used more fully and produce the best results if it continues to be State-based and operated. Conflicts between Federal regulations and State plans have been and will continue to be addressed and resolved.

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